



Department of Veterans Affairs Office of Inspector General

Combined Assessment Program Review of the Salem VA Medical Center Salem, Virginia

Office of Inspector General

Combined Assessment Program Reviews

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care is provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections and Investigations to provide collaborative assessments of VA medical facilities on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical and benefits services.
- Determine if management controls ensure compliance with regulations and VA policies, assist management in achieving program goals, and minimize vulnerability to fraud, waste, and abuse.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

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Executive Summary

Introduction

The Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA Medical Center (VAMC or the medical center), Salem, VA, during the week of May 15–18, 2006. The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we provided fraud and integrity awareness training to 214 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 6.

Results of Review

The CAP review focused on seven areas. The medical center complied with selected standards in the following five areas:

- All Employee Survey (AES)
- Diabetes and Atypical Antipsychotic Medications
- Environment of Care (EOC)
- Quality Management (QM)
- Survey of Healthcare Experiences of Patients (SHEP)

We identified two areas that needed additional management attention. To improve operations, we made the following recommendations:

- Strengthen communication of suspicious or abnormal mammogram results to providers and patients.
- Strengthen working relationships with contract nursing home ombudsmen.

This report was prepared under the direction of Ms. Virginia Solana, Director, and Ms. Dorothy Duncan, Associate Director, Kansas City Regional Office of Healthcare Inspections.

VISN 6 and Medical Center Director Comments

The Salem VA Medical Center Director and the VISN 6 Director agreed with the CAP review findings and provided acceptable improvement plans (see Appendixes A and B,

pages 14–18, for the full text of the Directors’ comments). We will follow up on the planned actions until they are completed.

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Introduction

Medical Center Profile

Organization. The medical center is a tertiary care facility that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at two community based outpatient clinics located in Danville and Tazewell, VA. The medical center is part of VISN 6 and serves a veteran population of about 30,000 residing in 26 counties in southwest Virginia.

Programs. The medical center has 182 hospital beds and 90 nursing home beds and operates several regional referral and treatment programs. It provides medical, surgical, mental health, geriatric, and rehabilitation services. The medical center partners with the Department of Defense through local and national sharing agreements. These agreements provide medical services to military reservists and to an Army Reserve medical unit which utilizes the medical center for training.

Affiliations and Research. The medical center is affiliated with the University of Virginia School of Medicine and the Edward Via Virginia College of Osteopathic Medicine, Virginia Polytechnic Institute and State University, and supports 47 resident positions. It has affiliations with numerous other institutions to train nursing and other allied health students. In fiscal year (FY) 2006, the medical center had 50 active research projects with 18 active principal investigators. Important areas of research include obesity, diabetes, osteoporosis, kidney disease, chronic obstructive pulmonary disease, asthma, pneumonia, atrial fibrillation, anemia, substance abuse, and post-traumatic stress disorder.

Resources. The medical center's medical care expenditures totaled about \$170 million in FY 2005. The FY 2006 budget is about \$164 million. In FY 2005, the medical center had 1,432.5 full-time equivalent employees (FTE), which included 73 physician FTE and 431 nursing FTE.

Workload. In FY 2005, the medical center treated over 30,000 unique patients. The inpatient workload in FY 2005 totaled 4,495 discharges, and the average daily census, including nursing home patients, was 256. The outpatient workload totaled 291,837 visits in FY 2005.

Objectives and Scope of the CAP Review

Objectives. CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care and benefits services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility operations focusing on patient care, quality management, and administrative controls.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope. We reviewed selected clinical and administrative activities to evaluate the effectiveness of patient care administration, QM, and management controls. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions. Management controls are the policies, procedures, and information systems used to safeguard assets, prevent errors and fraud, and ensure that organizational goals are met.

In performing the review, we inspected work areas, interviewed managers and employees, and reviewed clinical and administrative records. The review covered the following seven activities:

All Employee Survey	Environment of Care
Breast Cancer Management	Quality Management
Community Nursing Home Contracts	Survey of Healthcare Experiences of
Diabetes and Atypical Antipsychotic Medications	Patients

The review covered facility operations for FY 2005 and FY 2006 through March 31, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on the recommendations from our prior CAP review of the medical center (*Combined Assessment Program Review of the Salem VA Medical Center, Salem, Virginia*, Report No. 03-03210-109, March 18, 2004).

During this review, we also presented fraud and integrity awareness briefings for 214 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

In this report, we summarize selected focused inspections and state opportunities for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. Activities in the section titled “Other Observations” have no reportable conditions.

Results of Review

Organizational Strength

Dementia Unit

The dementia unit at the medical center works collaboratively with multiple services to provide holistic care for patients with dementia and Alzheimer's disease. Patients and families are first seen in the Memory Disorders Clinic and oriented to the entire scope of programs available to them. Families are connected to a support group early in the disease process to assist them with coping with this life changing event. Respite care is provided to veteran patients and families for 30 days each FY. The program has resulted in delayed hospitalization for patients, while providing families respite from the continual care needs of dementia patients.

The inpatient unit provides for safe and supportive care for patients in an environment that enhances their abilities, while assisting with disabilities. Some additional enhancements have been murals on the walls, a special palliative care room for patients nearing death, and an automobile in the courtyard which patients can "drive" or "tinker with." There is a specially decorated room, called Passages, which was painted by families of patients. The room has murals of the four seasons and is used for visiting, special parties, and group meetings. Special recognition for the unit was given by VISN 6 and the program was featured in a recent edition of the VA publication "Vanguard."

Opportunities for Improvement

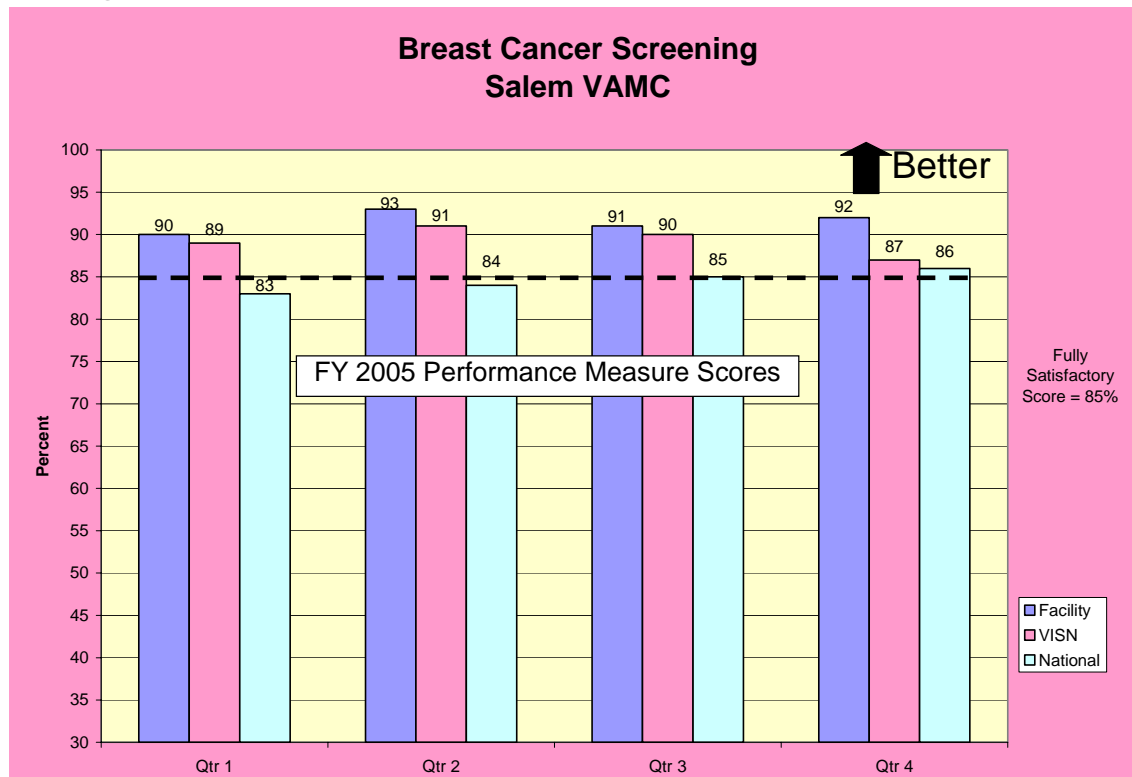
Breast Cancer Management

Conditions Needing Improvement. Fee basis facilities needed to report suspicious or abnormal mammography results to the medical center providers who ordered the procedures and to patients within the required timeframes. Medical center managers need to ensure that timely, written reports are included in the medical record. The medical center refers all patients to fee basis facilities for mammography procedures.

The VHA breast cancer screening performance measure assesses the percent of patients screened according to prescribed timeframes. Timely screening, diagnosis, communication, interdisciplinary treatment planning, and treatment are essential to early detection, appropriate management, and optimal patient outcomes. VHA mammography standards require normal findings to be documented in the medical record within 30 days of the procedure. Suspicious or abnormal results must be communicated to the ordering provider within 3 working days. Communication can be by telephone contact between the mammography procedure site and the ordering provider. If this is the method

adopted, the communication must be documented in the patient's medical record. Timely results need to be available and accessible to guide patient care and treatment.

Findings.



Patients appropriately screened	Mammography results reported to patients within 30 days	Patients appropriately notified of their diagnoses	Patients received timely consultations	Patients received timely biopsy procedure
6/8	5/8	4/5	3/3	5/5

We assessed these items in a review of eight patients diagnosed with breast cancer or who had abnormal mammography during FY 2005. Although the medical center met the VHA performance measure for breast cancer screening for FY 2005, two of the eight cases we reviewed were not appropriately screened.

The fee basis facilities sent written reports of procedures and recommendations for follow-up to the medical center, but three of the eight reports were not entered in the medical records within 30 days of the mammograms. Five of the eight suspicious mammography results were not documented as communicated to the VA provider within 3 days. There was no documentation in three of the eight medical records that

mammography results had been communicated to the patients. Providers noted abnormal findings of either mammography or biopsies and obtained timely consultations and treatment. However, based on documentation, it was unclear how findings were communicated.

During the first part of FY 2005, the fee basis facilities received orders for mammograms from multiple providers. The facilities sent facsimile reports to multiple departments in the medical center, and it was difficult for anyone to track these reports and scan them into the computerized medical record. The medical center had implemented changes to this process prior to our visit; however, the records we reviewed were prior to this change.

Recommendation 1. We recommended that the VISN Director ensure that the Medical Center Director implements a process to evaluate that: (a) all patients meeting criteria are appropriately screened for breast cancer, (b) written mammography reports are entered into the medical record within 30 days, (c) communication of suspicious or abnormal reports is documented in the medical record, and (d) mammography results are communicated to patients within 30 days and communication is documented in the medical record.

The VISN and Medical Center Directors agreed with the findings and recommendations. The medical center implemented changes in the middle of FY 2005 to capture all patients who meet criteria for breast cancer screening. Women's Health Clinic employees scan mammography reports into medical records within the required timeframe and document the communication of suspicious or abnormal reports to providers. The mammography contractor communicates written results to veterans and documents this communication on the reports that are scanned into the medical record. The improvement actions are acceptable, and we will follow up on reported implementation actions to ensure they have been completed.

Community Nursing Homes

Condition Needing Improvement. The community nursing home (CNH) review team needed to meet annually with all ombudsmen representing their contracted nursing homes.

VHA oversight of contract CNHs requires a minimum annual meeting with each veteran benefits office and local ombudsman office representing all veterans covered under a contract in CNHs. The purpose of these meetings is to develop a working relationship and discuss items of mutual concern.

The medical center had contracts with eight CNHs. The CNH team had not met during the last year with two of the eight ombudsmen. The CNH team attended community council on aging meetings that six of the ombudsmen also attended. This was the forum

for discussion of areas of concerns or interest. Because the other two ombudsmen were not located in the immediate area, they were not members of the community council. The CNH team had not arranged meetings with them. They had made telephone contact with them the week prior to our review but had not met annually as required.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director takes action to implement a process for meeting annually with all ombudsmen who represent contract nursing homes.

The VISN and Medical Center Directors agreed with the findings and recommendations. The coordinator of the CNH program will meet annually with the ombudsmen who were not included in the community council on aging meetings. The implementation plan is acceptable, and we will follow up on reported implementation actions to ensure they have been completed.

Other Observations

All Employee Survey

The Executive Career Field (ECF) Performance Plan for FY 2005 required that VISN directors ensure that the results of the 2004 AES were disseminated throughout their networks during the FY 2005 rating period. In addition, VISNs were required to analyze the survey results and help facilities formulate improvement plans to address deficient areas. These plans were to include timelines and milestones that would effectively measure improvements.

The medical center met the requirements for an ECF performance plan for FY 2005. Managers disseminated the AES survey results through service level meetings, electronic messages, and information posted on the medical center's intranet and in their newsletter. Managers completed a detailed analysis of the survey results, identified areas for improvement, and formulated appropriate action plans.

Diabetes and Atypical Antipsychotic Medications

Mental health patients receiving atypical antipsychotic medications were appropriately screened and managed. The purpose of this review was to determine the effectiveness of diabetes screening, monitoring, and treatment of mental health patients receiving atypical antipsychotic medications (medications that cause fewer neurological side effects but increase the risk for the development of diabetes).

VHA clinical practice guidelines for the management of diabetes suggest that: a diabetic patient's hemoglobin A1c (HbA1c), which reflects the average blood glucose level over a period of time, should be less than 9 percent to avoid symptoms of hyperglycemia; blood pressure should be less than or equal to 140/90 millimeters of mercury (mmHg); and low

density lipoprotein cholesterol (LDL-C) should be less than 120 milligrams per deciliter (mg/dL).

To receive fully satisfactory ratings for these diabetes performance measures, the medical center must achieve the following scores:

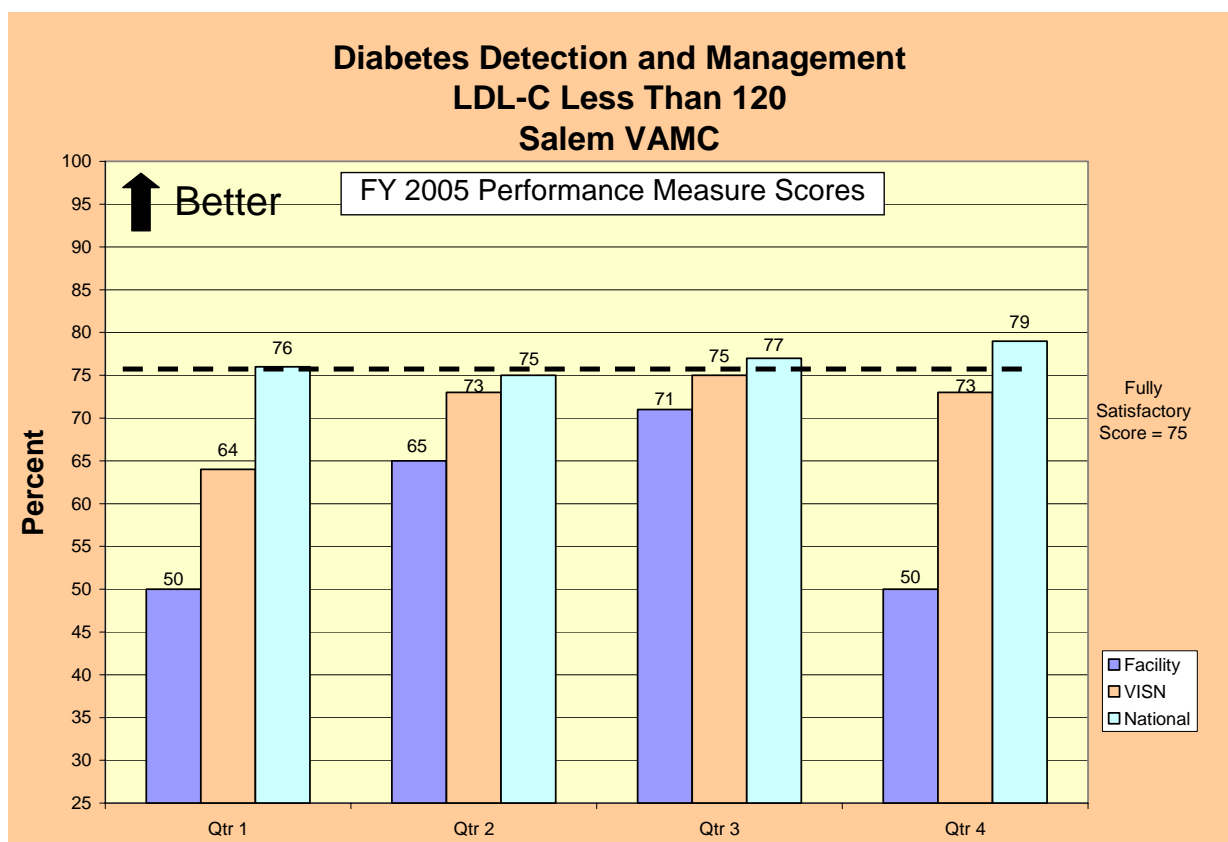
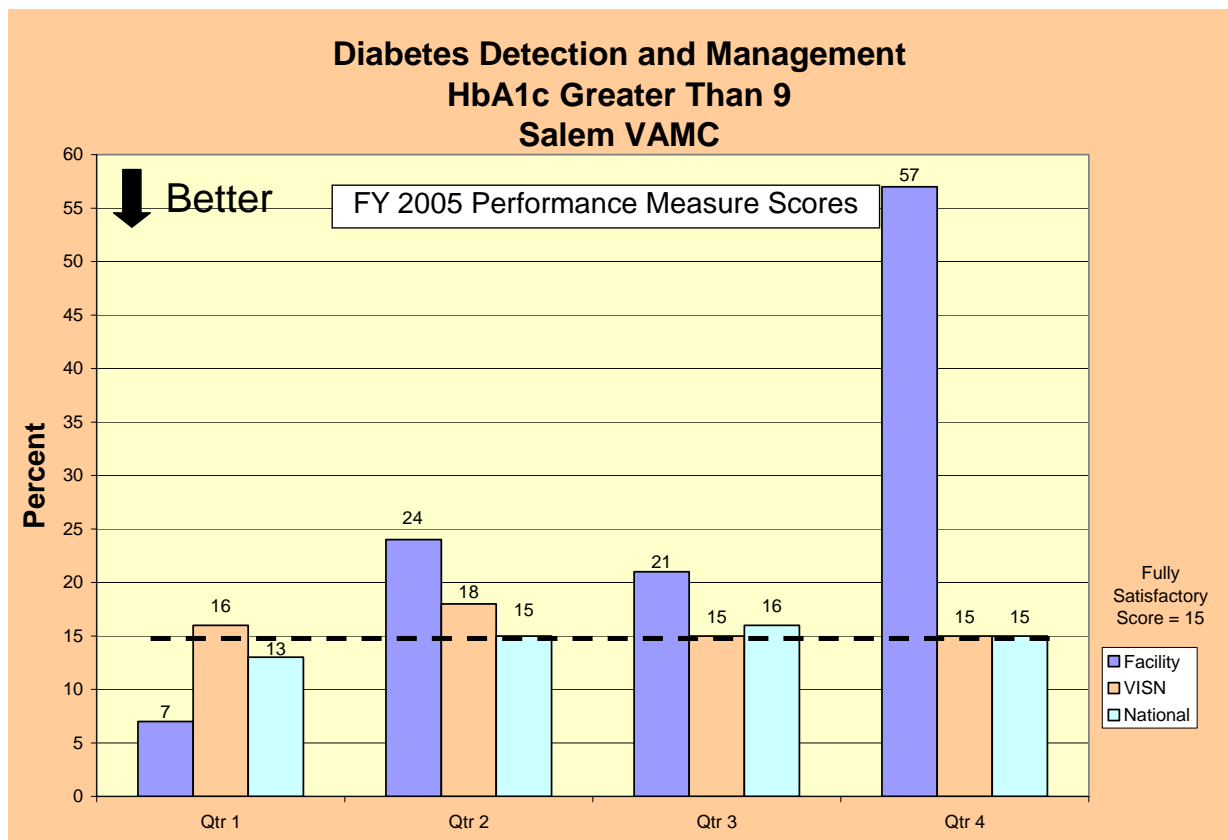
- HbA1c greater than 9 percent – 15 percent or lower
- Blood Pressure less than or equal to 140/90mmHg – 72 percent or higher
- Cholesterol (LDL-C) less than 120mg/dL – 75 percent or higher

VHA clinical practice guidelines for screening patients who are at risk for the development of diabetes suggest that fasting blood glucose (FBG) is the preferred screening test and should be performed every 1–3 years. A normal FBG is less than or equal to 110 mg/dL. Patients with FBG values greater than 110mg/dL but less than 126 mg/dL should be counseled about prevention strategies (calorie restricted diets, weight control, and exercise).

We reviewed a sample of 13 patients who were on one or more atypical antipsychotic medications for at least 90 days. Five of the 13 patients had diabetes, and clinicians had screened the other 8 patients for diabetes and counseled them about diabetes prevention. Clinicians had appropriately managed the care of the diabetic patients. Although one patient had an HbA1c above the desired range, a diabetic specialist followed him.

Diabetic patients with HbA1c greater than 9 percent	Diabetic patients with blood pressure less than 140/90mm/Hg	Diabetic patients with LDL-C less than 120mg/dL	Non-diabetic patients appropriately screened	Non-diabetic patients who received diabetes prevention counseling
1/5	5/5	5/5	8/8	8/8

The medical center met or exceeded VHA performance measures for blood pressure monitoring and control. However, the medical center did not meet VHA performance measures for HbA1c and did not meet cholesterol control for diabetic patients.



Senior managers had completed a detailed analysis of the performance measures results, identified areas for improvement, and formulated appropriate action plans. Because the patients in our review met criteria and the medical center had identified areas for improvement and implemented appropriate action plans, we made no recommendations.

Environment of Care

The medical center's EOC was clean and effectively maintained. VHA regulations require that the hospital environment present minimal risk to patients, employees, and visitors, and that infection control practices are employed to reduce the risk of hospital-acquired infections. We inspected key patient care areas, including a sample of occupied and unoccupied patient rooms and restrooms. We reviewed a sample of biomedical equipment and determined that it was in working order and properly cleaned, maintained, and tested. We did not identify any environmental deficiencies.

Quality Management

The QM program provided comprehensive oversight of the quality of care. To evaluate QM activities, we interviewed the medical center Director, Chief of Staff, Chief Nurse Executive, and QM personnel, and we evaluated plans, policies, and other relevant documents. For the purpose of this review, we defined a comprehensive QM program as including the following program areas:

- QM and Performance Improvement (PI) committees, activities, and teams.
- Patient safety functions (including healthcare failure mode and effects analyses, root cause analyses, aggregated reviews, and patient safety goals).
- Risk management (including disclosure of adverse events and administrative investigations related to patient care).
- Utilization management (including admission and continued stay appropriateness reviews).
- Patient complaints management.
- Medication management.
- Medical record documentation reviews.
- Blood and blood products usage reviews.
- Operative and other invasive procedures reviews.
- Reviews of patient outcomes of resuscitation efforts.
- Restraint and seclusion usage reviews.
- Staffing effectiveness analyses.

We evaluated monitoring and improvement efforts in each of the program areas through a series of data management process steps. These steps were consistent with Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) standards and included:

- Identifying problems or potential improvements.
- Gathering and critically analyzing the data.
- Comparing the data analysis results with established goals or benchmarks.
- Identifying specific corrective actions when results do not meet goals.
- Implementing and evaluating actions until the problems are resolved or the improvements are achieved.

We also evaluated whether clinical managers appropriately used the results of quality monitoring in the medical staff reprivileging process. Also, we reviewed mortality analyses to determine the level of facility compliance with VHA guidance.

We found that the QM program provided comprehensive oversight of the quality of care. Generally, when problems were identified, actions were taken and adequately evaluated. We found good senior management support and clinician participation.

Survey of Healthcare Experiences of Patients

The Survey of Healthcare Experiences of Patients (SHEP) scores exceed national targets. Veteran patient satisfaction surveying is designed to promote health care quality assessment and improvement strategies that address patients' needs and concerns, as defined by patients. In 1995, VHA began surveying its patients using a standardized instrument modeled from the Picker Institute, a non-profit health care surveying group. Measure 21 of the VHA ECF performance plan for FY 2006 requires that in FY06 the percent of patients reporting overall satisfaction of Very Good or Excellent will meet or exceed targets in:

For FY 2006 the targets were:

a.	Ambulatory Care	Meets Target:	77%
		Exceeds Target:	80%
b.	Inpatients	Meets Target:	76%
		Exceeds Target:	79%

The following tables show the medical center's SHEP results for inpatients and outpatients.

Dates of Survey Reporting Period:
FY 2006 1st and 2nd Quarters

[illegible]

Dates of survey reporting period:
FY 2006 1st Quarter

[illegible]

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Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: July 28, 2006
From: Director, Veterans Integrated Service Network (10N6)
Subject: Salem VA Medical Center, Salem, VA
To: Director, Kansas City Regional Office of Healthcare
Inspections (54KC)

Attached is Salem's response to the draft report on the
CAP review.

(original signed by:)

DANIEL F. HOFFMANN, FACHE

cc: Director, Management Review Office (10B5)

Director's Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendation and suggestions in the Office of Inspector General Report:

OIG Recommendation(s)

Recommendation 1. We recommended that the VISN Director ensure that the Medical Center Director implements a process to evaluate that: (a) all patients meeting criteria are appropriately screened for breast cancer, (b) written mammography reports are entered into the medical record within 30 days, (c) communication of suspicious or abnormal reports is documented in the medical record, and (d) mammography results are communicated to patients within 30 days and communication is documented in the medical record.

Concur

Target Completion Date: July 1, 2006

During 2005, the staff involved with mammography made several changes in order to correct deficiencies recognized by them. Changes made were commented upon on pages 5 and 6 of this report. Changes were made in midyear, therefore did not completely meet the intent of the guidelines reviewed by the OIG-CAP team.

a. Responsibility for mammography ordering and follow-up was given to the Women's Health program. Primary care clinical providers refer all female patients to Women's Health for mammograms, thus capturing all patients meeting criteria for appropriate screening. This process was implemented in mid-2005 as recognized by the OIG-CAP team in this report.

b. Written reports are received from the contractor via fax. In mid-2005, the reports began being entered by the Women's Health Clinic into the CPRS system by scanning the reports, thus making them available to the providers within the 30 day time frame. Should the staff in Women's Health be unavailable for any reason to enter the reports, the back-up system is the radiology department. Since mid-2005, reports have been entered in a timely manner.

c. Faxed reports contain information regarding suspicious or abnormal findings. The contractor for mammography contacts both the patient and Women's Health at the Salem VAMC when findings are abnormal. The patient is scheduled for appropriate follow-up diagnostic studies while at the same time the provider in Women's Health sends a physician order for the appropriate study to be completed. Both the report and the order are part of the CPRS system and are documented in the patient's record.

d. Mammography results are communicated with each patient via a letter from the contractor. In order to document this communication in the VHA CPRS system, the contractor now states this communication on the report that is presently faxed to the Salem VAMC. Thus when the report is scanned into CPRS, the comment "Notification of Results Sent to the Patient" will be present in the patient's record.

All recommendations are now completely implemented.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director takes action to implement a process for meeting annually with all ombudsmen who represent contract nursing homes.

Concur

Target Completion Date: July 18, 2006

The Chief, Extended Care Service Line and the Coordinator of the Community Care Program currently meet bi-monthly with the Roanoke AAA Ombudsmen in whose area are three (3) of our Community Nursing Homes, currently representing six (6) veterans under VA contract. These meetings will continue. The Coordinator of the Community Nursing Home Program will begin annual meetings with the five (5) Ombudsmen in whose areas are six (6) of our Community Nursing Homes, currently representing three (3) veterans under VA Contract. The purpose of both forums is to develop a working relationship and to discuss items of mutual concern regarding care of our veteran patients in the Community Nursing Home setting. Documentation regarding these meetings will be in the Community Oversight Committee minutes. These two meetings with Ombudsmen meet the intent of the requirement and complete our response to this recommendation.

Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: July 18, 2006
From: Director, Salem VA Medical Center (658/00)
Subject: Salem VA Medical Center, Salem, VA
To: Director, Veterans Integrated System Network 6 (10N6)

Please find above our response to the two (2) recommendations from our May 2006 OIG-CAP inspection. With implementation of the actions in our response, we have responded fully to the recommendations in the report.

Thank you.

(original signed by:)

Carolyn L. Adams for

STEPHEN L. LEMONS, Ed.D.
Director

OIG Contact and Staff Acknowledgments

OIG Contact	Virginia L. Solana, Director Kansas City Regional Office of Healthcare Inspections 816 426-2023
Acknowledgments	Dorothy Duncan Jennifer Kubiak Darren Petri James Seitz Marilyn Stones

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